



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 11, 2017

Michael Blauer, Administrator
St. Luke's Elmore Long Term Care
PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Blauer:

On **September 1, 2017**, a Facility Fire Safety and Construction survey was conducted at **St. Luke's Elmore Long Term Care** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 25, 2017**. Failure to submit an acceptable PoC by **September 25, 2017**, may result in the imposition of civil monetary penalties by **October 14, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 6, 2017**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 6, 2017**. A change in the seriousness of the deficiencies on **October 6, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 6, 2017**, includes the following:

Denial of payment for new admissions effective **December 1, 2017**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 1, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 1, 2017**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Michael Blauer, Administrator
September 11, 2017
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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **September 25, 2017**. If your request for informal dispute resolution is received after **September 25, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF WING B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2017
NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story Type V(111) wing attached to a deemed Hospital. The facility was built in 1965 with major renovations and additions in 1996-98, most of which were in the hospital portion of the building. Renovation to the nursing home was completed in 2004. The facility is fully sprinklered with a new sprinkler system installed in March 2009 and has a recently updated fire alarm system. Currently the facility is licensed for 38 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on September 1, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction NFPA 101 Cooking Facilities	K 000			
K 324 SS=D	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324	The Building Services manager is ultimately responsible for ensuring to maintain the kitchen hood in accordance with NFPA. All residents had the potential to be affected by this citation. Plan of Correction: - A hood test was already scheduled and the vendor completed the work on 9/20/17.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 324	<p>Continued From page 1</p> <p>or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the fire suppression system for the kitchen hood in accordance with NFPA 17. Failure to maintain Kitchen hood suppression systems could result in a lack of system performance, allowing fires to grow outside the protected area. This deficient practice affected staff in the kitchen on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During document review on September 1, 2017, from approximately 10:00 AM to 2:30 PM, inspection records provided for the kitchen hood suppression system revealed the hydrostatic test of the ANSUL system tank was past due. It was identified by the vendor on the semi-annual inspection in January 2017 and again in July 2017. Interview of the Facilities Director revealed the facility had overlooked the deficiency noted on the semi-annual inspection report and was unaware the tank was over due for the</p>	K 324	<p>- The kitchen hood testing was included in the ongoing Building Services preventative maintenance schedule to signal upcoming due dates of inspection to ensure ongoing compliance.</p> <p>QAPI Integration</p> <p>- Systematic changes put into place. Building Services will monitor to ensure ongoing compliance.</p> <p>Date of Compliance: 10/2/2017</p>		

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K 324	Continued From page 2 hydrostatic testing. Actual NFPA standard: NFPA 17 11.5.1* The following parts of dry chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (1) Dry chemical containers (2) Auxiliary pressure containers (3) Hose assemblies Exception No. 1: Dry chemical containers that are part of extinguishing systems having an agent capacity exceeding 150 lb (68 kg). Exception No. 2: Auxiliary pressure containers not exceeding 2 in. (0.05 m) outside diameter and less than 2 ft (0.6 m) in length. Exception No. 3: Auxiliary pressure containers bearing the DOT "3E" marking.	K 324			
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater	K 325	The Director of Operations is ultimately responsible for ensuring the ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. All residents had the potential to be affected by this citation. Plan of Correction: - On 9/20/17 the ABHR dispensers on the long term care unit were tested for proper functioning.		

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K 325	<p>Continued From page 3</p> <p>than 5 gallons complies with NFPA 30</p> <ul style="list-style-type: none"> * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could result in inadvertently spilling flammable liquids, increasing the risk of fires. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF residents and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on September 1, 2017 from approximately 10:00 AM to 2:30 PM, no records were available indicating ABHR dispensers were tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR dispensers were observed throughout the facility and when asked, the Facilities Director stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p>	K 325	<p>- The facility will ensure that an ABHR dispenser log will be kept, and each new refill will be documented with date of change of product and proper functioning of the dispenser.</p> <p>- Building Services will provide an in service with the Environmental Services Manager as to refill instructions, inspections and documentation.</p> <p>QAPI Integration:</p> <p>- ABHR testing will be added to the EOC Audits. Audit data will be reviewed at Environment of Care meeting monthly.</p> <p>Date of Compliance: 10/2/17</p>		

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K 325	Continued From page 4 Actual NFPA standard: NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the	K 325			

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K 325	Continued From page 5 requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer's care and use	K 325			

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K 325 K 712 SS=F	<p>Continued From page 6</p> <p>instructions each time a new refill is installed.</p> <p>NFPA 101 Fire Drills</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of required fire drills, one per shift per quarter. Failure to perform fire drills on each shift quarterly could result in confusion and hinder the safe evacuation of residents during a fire event. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on September 1, 2017 from approximately 10:00 AM to 2:30 PM, fire drill documentation revealed the facility failed to perform fire drills on third shift both first and second quarters of 2017. When asked, the Facilities Director stated the facility was unaware</p>	K 325 K 712	<p>The Building Services manager is ultimately responsible for ensuring documentation of required fire drills, one per shift per quarter.</p> <p>All residents had the potential to be affected by this citation.</p> <p>Plan of Correction:</p> <ul style="list-style-type: none"> - Developed a 12-month fire drill calendar with specific dates to comply with requirements. - The Education department will provide an in-service for current Building Services on Fire Drill documentation requirements according to NFPA/CMS guidelines completed on 9/22/17. Additionally, new employee education was developed. <p>QAPI Integration:</p> <ul style="list-style-type: none"> - The EOC Code Committee will review the calendar monthly, including review of After Action Reports, to ensure compliance. <p>Date of Compliance: 10/2/17</p>		

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K 712	Continued From page 7 of the missing fire drills. Actual NFPA standard: 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			
K 926 SS=D	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were properly trained on the risks associated with the handling and use of medical gases. Failure to provide an education program which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders, could result in a life threatening or catastrophic accident. This deficient practice could potentially affect residents using oxygen on the date of the survey. The facility is licensed for 38 SNF/NF residents and had a census of 18 on the day of the survey. Findings include:	K 926	The Director of Nursing (DNS) is ultimately responsible for ensuring staff are properly trained on the risks associated with the handling and use of medical gases. No residents had the potential to be affected by this citation. Plan of Correction: - Norco to provide an in service with the current staff. Hands-on competency assessment will be completed by Education and Respiratory Services. - Ongoing training associated with the handling and use of medical gases for current employees and new staff to be completed on hire and annually. QAPI Integration: - Education to conduct periodic review of in service records to ensure		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF WING B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2017
NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 926	<p>Continued From page 8</p> <p>During the review of facility training records conducted on September 1, 2017 from approximately 10:00 AM to 2:30 PM, no records were available indicating that the facility maintains an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Director of Nursing stated the facility was not currently conducting periodic training and was unaware of the requirement.</p> <p>NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.</p> <p>NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.</p>	K 926	<p>that proper training is taking place.</p> <p>Date of Compliance: 10/2/17</p>		